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RECEIVED and FILED by the
NEW JERSEY STATE BOARD OF
VETERINARY MEDICAL EXAMINERS
on this date of: 10-10-10

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STATE OF NEW JERSEY
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
BOARD OF VETERINARY MEDICAL EXAMINERS

IN THE MATTER OF

CARLOS TRIANA, D.V.M.

TO PRACTICE VETERINARY MEDICINE
IN THE STATE OF NEW JERSEY

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Administrative Action

CONSENT ORDER

This matter was opened to the State Board of Veterinary Medical Examiners (hereinafter referred to as the "Board") following the Board's review of a consumer complaint filed by Y. M. following her visit with her pet to Carlos Triana, D.V.M. In her complaint to the Board, Y.M., among other contentions, alleged that the Respondent, Dr. Triana, engaged in negligence and professional misconduct in the treatment of her eight (8) month old pit bull dog, "Shi," in January 2008.

The Board's review of this matter revealed that Shi was presented to the Union City Animal Clinic ("Clinic") on January 19, 2008 for spaying. Dr. Triana, is a New Jersey licensed veterinarian who treated Shi at the Clinic.

Following the surgery on Saturday, January 19, 2008, Y.M. found the dog was "really out of it." Later that night, Y.M. noticed bleeding from Shi's incision, and three staples on the side of the incision instead of directly on the incision.

Y.M. brought Shi back to the Clinic on Monday, January 21, 2008. She indicated that the veterinarian told her that he was going to remove the three staples, apply new staples, and that the procedure would be done without anesthesia. When she returned to pick up her dog, Y.M. found that the veterinarian had removed all of the staples and had applied stitches. She observed that Shi was shaking and that her eyes were blood red. The owner maintains that no anesthesia was used during this procedure, and that she was never informed of this procedure in advance. According to Y.M., Shi was sent home without any pain medication.

Instead of taking Shi directly home, the owner took her to the Animal Infirmary of Hoboken because of her condition and as Shi felt very hot. Shi was given an injection for pain and was sent home with pain medication and antibiotics.

Dr. Triana advised the Board in correspondence that on January 19, 2008, he was instructed to operate on Y.M.'s dog and that the

surgery was a success and without complications. Shi was kept for observation for approximately two hours and sent home with an E-collar and instructions to keep it tight around her neck.

Dr. Triana reported that Y.M. returned to the Clinic two days later, and that Shi was admitted due to redness of the incision and two loose staples. Dr. Triana was instructed to treat Shi once again. He found her E-collar to be loose and determined that because the dog had been biting the incision excessively, the incision had opened slightly. He also found two mis-placed staples. Dr. Triana reported that twelve (12) cc propofol IV were given, the staples were removed, and a single interrupted suture (2.0) vicryl was placed. The dog was observed for one hour and sent home with antibiotics prescribed by Dr. Jay Kim, the Clinic's owner.

In correspondence to the Board, Holly Anne Hansen, D.V.M., of the Animal Infirmary of Hoboken reported that when Shi was brought to her office on January 21, 2008, she observed a small white packet of yellow and white capsules that had been prescribed by the Clinic's attending doctor. The packet was labeled "Dog" and "1 tab PO BID" with no indication as to what type of medication it contained. Dr. Hansen stated that Shi was wearing an E-collar, was panting heavily, and was restless. Her temperature was 104 degrees, and Shi was dehydrated. She observed that the spay site was abnormally swollen and warm to the touch, the swelling

approximately the size of a golf ball. There was no obvious discharge; however, the incision was extremely irritated. A physical examination was performed and medications were provided.

The Board, following its review of the relevant documents in this matter, found that Dr. Triana engaged in repeated acts of negligence in his care and treatment of Shi, in violation of N.J.S.A. 45:1-21(d), due to the following: 1) the type of surgical technique used during the procedure, in that the original staples were poorly placed, as demonstrated by the fact that Shi's incision had opened and two staples were found by Dr. Triana to be misplaced; and 2) the fact that he failed to provide pain medication.

The Board has also concluded that Dr. Triana violated or failed to comply with its patient record regulation, N.J.A.C. 13:44-4.9, in that his medical records for Shi do not contain information required by the regulations. Specifically, the Board noted that the records completed by Dr. Triana failed to contain the following information, including, but not limited to: 1) identification of the treating doctor; 2) no discussion of the surgical procedure, i.e., spay, the drugs administered during the procedure, and/or the medications prescribed; 3) inadequate information regarding the "restitch" procedure of Shi. This conduct constitutes a violation of N.J.S.A. 45:1-21(h), and specifically, N.J.A.C. 13:44-4.9, and therefore, establishes a basis for disciplinary action.

The parties desiring to resolve this matter without the need for further disciplinary proceedings; and the respondent acknowledging and not contesting the findings of the Board and waiving his rights to a hearing in this matter; and the Board having been satisfied that the within resolution adequately protects the public health, safety and welfare, and for good cause shown:

IT IS, THEREFORE, ON THIS 9TH DAY OF *June* 2010,

ORDERED THAT:

1. The Respondent, Carlos Triana, D.V.M., is hereby reprimanded for his conduct as described above, in violation of N.J.S.A. 45:1-21(d) and N.J.S.A. 45:1-21(h).

2. The Respondent shall take and successfully complete, and provide to the Board proof of successful completion, a minimum of ten (10) credit hours of Board approved courses of continuing education within six (6) months of the date of this Order. These credits shall consist of training in surgical technique. All continuing education course taken by the Respondent to fulfill this requirement shall be RACE approved. Additionally, no continuing education credits completed in compliance with this Consent Order may be used to satisfy the minimum continuing education requirements for any biennial renewal period.

3. Dr. Triana shall pay a civil penalty in the aggregate amount of **\$3500.00** for the following violations: 1)

\$2,000.00 for engaging in repeated acts of negligence, in violation of N.J.S.A. 45:1-21(d); and 2) \$1,500.00 for record keeping violations, contrary to N.J.S.A. 1:45-1.21(h) and N.J.A.C. 13:44-4.9. Payment for the civil penalty shall be submitted contemporaneously with the signing of this Order, by certified check or money order, made payable to the State Board of Veterinary Medical Examiners and shall be forwarded to Leslie G. Aronson, Executive Director, Board of Veterinary Medical Examiners, 124 Halsey Street, Sixth Floor, Post Office Box 45020, Newark, New Jersey 07101. Subsequent violations will subject respondent to enhanced penalties subject to N.J.S.A. 45:1-25. Failure to pay the penalty within the time period allotted above will result in the filing of a Certificate of Debt, including the applicable interest permitted by the New Jersey Court Rules, and may result in subsequent disciplinary proceedings before the Board for failure to comply with an Order of the Board.

3. Failure to comply with any of the provisions of this Consent Order or to timely remit any and all payments required by this Order will result in the filing of a certificate of debt and may result in subsequent disciplinary proceedings for failure to comply with an Order of the Board.

NEW JERSEY STATE BOARD OF
VETERINARY MEDICAL EXAMINERS

By: Mark W. Logan VMD
MARK W. LOGAN, V.M.D.
President

I have read and understand the
within Consent Order and agree
to be bound by its terms. Consent
is hereby given to the Board to
enter this Order.

Carlos Triana
CARLOS TRIANA, D.V.M.

4/19/2010
DATED: